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No. 07-576

FILED
JAN 17 2008
OFFICE OF THE CLERK
SUPREME COURT, U.S.

IN THE

Supreme Court of the United States

COOK CHILDREN'S MEDICAL CENTER,

Petitioner,

v.

THE NEW ENGLAND PPO PLAN OF GENERAL CONSOLIDATED MANAGEMENT INC; DEBORAH HANSEN, FIDUCIARY and NEW ENGLAND LIFE INSURANCE COMPANY,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

REPLY BRIEF

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STATEMENT PURSUANT TO RULE 29.6

Petitioner's Rule 29.6 Statement was set forth at page *ii* of its Petition for a Writ of Certiorari, and there are no amendments to that Statement.

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Petitioner COOK CHILDREN'S MEDICAL CENTER replies to the Brief in Opposition for Respondent New England Life Insurance Company:

ARGUMENT

I. Respondent does not address the Question Presented.

Respondent's brief does not respond to the Question Presented in Cook Children's petition for certiorari, which is: Did the court below err in enforcing Mr. Miller's waiver of available ERISA plan health care benefits for David C. under Respondent's ERISA Plan when the sole purpose of the waiver was to obtain Medicaid benefits in contravention of the public policy that any person with available ERISA health care plan benefits or private health care insurance cannot obtain Medicaid benefits.

Instead of addressing the question, Respondent sidesteps by presenting its own "Counterstatement of Questions Presented" (Respondent's Brief, p. 1), in which Respondent mistakenly argues, as it repeatedly does in the balance of its brief, that "Mr. Miller elected to not enroll his son David C." in the Respondent plan.

II. David C. was automatically covered by the Plan.

Respondent's "elected to not enroll" argument is a fallacious conclusion based upon the false assumption Mr. Miller was required to enroll his son in the Plan to obtain its coverage. To the contrary, the Summary Plan Description provides that Respondent's Plan *automatically* covered those persons who were covered

by the employer's prior plan on the date the prior plan terminated. (*See* Cook Children's Record Excerpts, Tab 6, p.1.) Automatic coverage dispenses with any necessity to enroll such persons in Respondent's Plan. *United of Omaha Life Ins. v. Sun Life Ins.*, 894 F.2d 1555, 1559 (11th Cir. 1990). ("Because Wells was automatically covered by the basic insurance of the group policy, no application was necessary.") It is undisputed that David C. was covered by the employer's prior plan on the date that the prior plan was terminated. As Respondent's brief (p.5) admits, Respondent's Summary Plan Description provided that the employee could (1) elect not to be covered or (2) waive all coverages except Life and AD&D Insurance or (3) waive coverage for medical and prescription drugs only. However, Mr. Miller did not "elect not to be covered", since it is undisputed by Respondent that Mr. Miller, his wife, and two of his three children were covered by Respondent's Plan.

The fact is that Mr. Miller did not "choose to not enroll David C in the Plan", (as Respondent now asserts, but rather chose to *waive the coverage* for David C under the Plan (as Respondent asserted in the courts below); and it is undisputed that Mr. Miller did so to qualify his son to receive Medicaid benefits.

III. The Administrator's interpretation of the Plan was not legally correct.

In *Wildbur v. ARCO Chemical Co.*, 974 F.2d 631, 637-638 (5th Cir. 1992), the Court detailed the two-step procedure to be followed when a court reviews a plan administrator's decision on a claim. *First, the court must determine the legally correct interpretation of the plan.*

If the administrator did not give the plan the legally correct interpretation, the court must *then determine whether the administrator's decision was an abuse of discretion.* In determining whether the administrator's interpretation of the plan was legally correct, the court must consider, *inter alia,* whether the administrator's *interpretation is consistent with a fair reading of the plan.*

Respondent argues that the Administrator was not required to consider relevant law in deciding Cook Children's claim. However, *Wildbur* teaches that the *reviewing court* must determine whether the Administrator's interpretation of the Plan was *legally correct* and if not, whether the decision was an abuse of discretion, considering the *relevant regulations* and the factual background.

Respondent's brief and the Administrator's decision are both predicated on the incorrect and unwarranted interpretation that the Plan did not cover David C. unless Mr. Miller chose to enroll him. This is *not consistent* with a fair reading of the Plan. Under a fair reading of the Summary Plan Description, David C. *was automatically covered* by the Plan and there was no need for him to be "enrolled" to have the benefit of such coverage.

IV. The Administrator's denial of the claim was an abuse of discretion.

Since the Administrator failed to apply the legally correct interpretation of Respondent's Plan, under the procedure detailed in *Wildbur* at pp. 637-638, the reviewing courts were required to determine whether

the Administrator's denial of Cook Children's claim for services rendered to David C, was an abuse of discretion. In making this determination, the reviewing courts were required by *Wildbur* to consider, *inter alia,* (**a**) "any relevant regulations formulated by the appropriate administrative agencies" and (**b**) "the factual background of the determination and any inferences of lack of good faith."

A. The relevant regulations.

Cook Children's petition for certiorari cites statutes and regulations establishing the public policy that any person who has available health care plan benefits or health care insurance cannot obtain Medicaid benefits. Waiving available resources such as private insurance or ERISA plan health care benefits for the purpose of qualifying for Medicaid benefits contravenes that public policy. Respondent's brief (p. 11) concedes that public policy forbids a person from obtaining Medicaid benefits if that person has private health care plan benefits or health care insurance available.

Respondent's brief (p. 11) asserts that "if Mr. Miller had chosen to enroll David C, in the Plan at the outset, and then had lied about it (or failed to disclose it), then he may have violated the law." This supposed scenario differs little from what are the undisputed facts of this case, to-wit,

(1) David C. was automatically covered by the Plan at the outset and no act by Mr. Miller was necessary to secure such coverage; and

(2) in obtaining medical services for David C. from Cook Children's, Mr. Miller not only failed to disclose that David C. was automatically covered by the Plan, but in addition represented that Medicaid was primarily responsible to pay for such services, thereby implying that no private ERISA benefits or insurance was available.

B. The factual background.

The undisputed factual background is that Mr. Miller purposefully waived coverage of his son David C. by the Plan in attempting to qualify his son to receive Medicaid benefits. Such a waiver plainly contravenes public policy, and the question is whether the courts below erred by enforcing such a waiver.

Respondent concedes that Medicaid is secondary to a private insurance plan, but asserts, without any reference to statutory, regulatory or case law authority in support thereof, that this public policy is overruled at the whim of a seeker of public Medicaid benefits by the simple waiver of available ERISA health care plan benefits or private health care insurance. (Respondent's Brief, p 11.) Public policy should not be treated so whimsically.

CONCLUSION

Enforcement of Mr. Miller's waiver circumvents established public policy that health care paid for by public funding is reserved for persons without private resources to pay, and provides a "how-to-get-on-Medicaid" primer for persons with private resources who are dissatisfied with the co-pay requirements or other terms and conditions of their available private insurance or ERISA plan health care benefits. A simple waiver of that insurance or plan benefits will do it. Such ought not be.

This is an important question of federal law that, left unreviewed, would substantially adversely affect the federal treasury to the benefit of private ERISA health care plans and private health care insurance carriers.

Certiorari should be granted.

Respectfully submitted,

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